MISSOURI DEPARTMENT OF REVENUE
CUSTOMER ASSISTANCE BUREAU
301 WEST HIGH STREET - ROOM 225
JEFFERSON CITY, MO 65105-0200

PHYSICIAN'S STATEMENT

TELEPHONE: (573) 751-1489
FAX: (573) 522-8174
WEB SITE: **www.dor.mo.gov**

FORM **1528** (REV. 1-05)

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE COMPLETING THIS FORM!

- **Completing this report does not violate physician/patient privilege, and when made in good faith the physician shall be immune from any civil liability that might otherwise result from making this report.**
- **You should complete and sign the Physician's Statement based on your examination of the patient, and indicate if he or she is capable of operating a motor vehicle safely and responsibly.**

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	
PATIENT'S MAILING ADDRESS	CITY	STATE	ZIP CODE

MEDICAL CONDITIONS

PLEASE CHECK ☑ APPROPRIATE BOXES IF THE PATIENT BEING REPORTED HAS ANY OF THE FOLLOWING CONDITIONS THAT WOULD IMPAIR HIS OR HER ABILITY TO SAFELY OPERATE A MOTOR VEHICLE.

☐ **VISUAL IMPAIRMENT**

	Yes	No
Should patient be required to wear glasses/lenses while driving?	☐	☐
Should patient be restricted to daylight driving?	☐	☐
Does patient have visual field deficit which makes driving unsafe?	☐	☐

Additional comments: _____

VISION

DISTANT VISION ONLY	RIGHT	LEFT	BOTH
WITH PRESENT CORRECTION	20/	20/	20/
WITHOUT CORRECTION	20/	20/	20/
BEST POSSIBLE CORRECTION	20/	20/	20/
FIELD	**RIGHT** °	**LEFT** °	

EYE DOCTOR SIGNATURE	DATE

☐ **HEARING - DO NOT COMPLETE UNLESS PATIENT IS SEEKING A COMMERCIAL DRIVER LICENSE**

☐ Normal ☐ Other (Please explain) _____

☐ **COGNITIVE IMPAIRMENT**

☐ Impaired Problem Solving, Decision Making or Judgment

☐ Dementia

☐ Other (Please explain) _____

☐ **PSYCHIATRIC**

☐ Hallucinations or Delusions

☐ Other (Please explain) _____

☐ **DISORDERS THAT IMPAIR CONSCIOUSNESS**

☐ Medication Effect ☐ Disorders, such as Sleep Apnea, Narcolepsy, Other

☐ Epilepsy, Seizure Disorder, Other

☐ Blackouts
Date of Event with Impaired Consciousness _____

☐ Other (Please explain) _____

☐ **MUSCULOSKELETAL CONDITIONS**

☐ Paralysis ☐ Loss of Limb

☐ Restricted Range of Motion

☐ Other (Please explain) _____

☐ **ALCOHOL OR DRUG ABUSE**

(Please explain) _____

☐ **OTHER CONDITIONS**

(Please explain) _____

PLEASE ATTACH ADDITIONAL COMMENTS IF NECESSARY.

STATEMENT OF PHYSICIAN

DIAGNOSIS/ASSESSMENT

CONDITION IS: ☐ Permanent ☐ Temporary (please explain):

Are you the patient's regular physician? ☐ Yes ☐ No

If yes, how many times have you seen patient in the past year? _____

If no, have you reviewed the patient's medical records? _____

I have examined _____ on _____ and in my opinion he/she:

☐ is capable of operating a motor vehicle safely and responsibly without further evaluation at this time.

☐ is NOT capable of operating a motor vehicle safely and responsibly.

☐ must take the following test(s) in order to determine whether or not he/she is capable of operating a motor vehicle safely and responsibly: ☐ **written test** and/or ☐ **driving skills test**

I RECOMMEND THE FOLLOWING SPECIAL RESTRICTIONS AND/OR DEVICES WHILE DRIVING:

PHYSICIAN'S SIGNATURE ▶		DATE	
PHYSICIAN'S NAME (PRINT OR TYPE)	MEDICAL LICENSE NUMBER	TELEPHONE NUMBER ( )	
PHYSICIAN'S ADDRESS	CITY	STATE	ZIP CODE